Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MANDATORY MANAGED CARE

Children's Access to Medicaid Mental Health Services

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EXECUTIVE SUMMARY

PURPOSE

To describe access to Medicaid mental health services under mandatory managed care for children with serious emotional disturbances.

BACKGROUND

States are increasingly converting their Medicaid programs from traditional fee for service models to managed care models. Nearly every State has implemented, or is planning to implement, mandatory managed care for Medicaid beneficiaries who require mental health services. These mandatory managed care contracts typically include services for both adults and children.

We did not specifically focus our inspection on provision of mental health care to children. However, while completing our inspection on Mandatory Managed Care - Changes in Medicaid Mental Health Services (OEI-04-97-00340), we observed specific problems with children's access to care. This report describes our specific observations related to access to mental health services by children with serious emotional disturbances.

We used a case study approach for reviewing mandatory mental health managed care programs in seven States. We integrated, compared, and summarized documentary and testimonial evidence obtained from State Medicaid managed care offices and mental health departments. We also interviewed managed care organization officials, mental health providers, and stakeholders for children's mental health. We did not validate the testimonial evidence, however, the views of program operators and stakeholders were generally similar and consistent with documentary evidence. Therefore, we believe their opinions provide useful insight into early managed care programs and the accessibility of services for children with serious emotional disturbances.

FINDINGS

Respondents said that providing mental health services to children with serious emotional disturbances can present unique challenges not typically found when delivering services to adults. These challenges are generally systemic in nature and have existed for years under traditional fee for service care.

Although conversion to managed care does offer State Medicaid programs opportunities to improve mental health services for children, respondents told us that conversion can also intensify existing problems. When implementing mandatory managed care systems, States should be aware of obstacles that can interfere with access to mental health services for children.

Access To Care Is Limited

- < Reductions of in-patient care for children was greater than that for adults.
- < Children's out-patient services lag behind those for adults.
- < First year managed care contracts included limited provisions for children.

Responsibility for Care Is Fragmented

- < Respondents were concerned about possible cost shifting.
- < Multiple State agencies have responsibility.

States Attempt to Improve Coordination and Access

- < States have negotiated interagency agreements and reported improved coordination, but access to care by children is still limited.

RECOMMENDATIONS

Children's mental health out-patient services have increased after implementation of mandatory managed care. However, children's access to mental health services is still limited, and the provision of care is fragmented. While attempts by some States to reduce fragmentation seem promising, most respondents agree more needs to be done. Accordingly, we recommend that HCFA encourage States to:

Specify services for children's mental health care in managed care contracts.

Children's services appeared to be an afterthought in State's first year managed care contracts. Providing more detailed specifications on services managed care organizations will provide will help ensure that children receive the specialized care they require.

Develop interagency agreements to promote coordination of children's mental health services.

Better coordination of care and improved services for children were reported in States where agencies have established such agreements. Establishing closer working relationships also reduced cost shifting concerns among agencies.

AGENCY COMMENTS

Both HCFA and SAMHSA commented on our draft report.

HCFA concurred with our recommendation to encourage States to specify services for children's mental health care in managed care contracts. They prepared draft Interim Review Criteria for Children with Special Needs. States that mandatorily enroll children in capitated plans will be required to respond to the criteria as part of the waiver process.

Additionally, HCFA concurred with our recommendation to encourage States to develop interagency agreements to promote coordination of children's mental health services. HCFA plans to highlight the importance of such coordination in their imminent Report to Congress on special needs of vulnerable populations enrolled in Medicaid managed care.

SAMHSA commented that a number of our recommendations were useful, but expressed concern about drawing conclusions from what they believe is a study method that is not "scientific." We wish to emphasize that we used a case study method for our inspection. In describing our methodology we included a detailed explanation of the advantages and limitations of our case study approach. The limitations we point out are similar to those described by SAMHSA.

SAMHSA noted that the overall lack of consistent, detailed data was a possible major finding from our study. We agree. However, the problem is not limited to only children's programs. It is an issue we deal with explicitly in a companion report that addresses both children and adult mental health care. That report is titled *Mandatory Managed Care: Changes in Medicaid Mental Health Services* (OEI-04-97-00340).

Additionally, SAMHSA expressed concern that we may not have adequately included the views of State mental health staff and stakeholders. As shown in our methodology, we considered input from such groups as highly important. To illustrate, we interviewed at least 37 State mental health staff and stakeholders.

We made several technical changes suggested by SAMHSA.

The full text of HCFA and SAMHSA comments are in Appendix B.